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The next issue of the *South Central MIRECC Communiqué* will be published August 3, 2009. Deadline for submission of items to the July newsletter is July 24, 2009. Urgent items may be submitted for publication in the *Communiqué Newsflash* at any time. Email items to the Editor, Mary Sue Farmer, at Mary.Farmer2@va.gov

South Central MIRECC Internet site: www.va.gov/scmirecc

National MIRECC Internet site: www.mirecc.va.gov

WHAT IS RURAL?

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Defining Rural

Researchers interested in investigating access to mental health care and quality of care for rural populations have an overwhelming choice of options for defining an area or population as rural. Researchers and bureaucrats rely on numerous different measures to determine whether a region is rural, or the degree of rurality, although none of the measures was developed with precisely the needs of health services research in mind. Rather, they reflect various Federal agencies' needs to define rural in order to determine eligibility for their programs. There is no one best definition of "rural."¹ The complexities of the classification schemes available for researchers prompted the Washington State Department of Health's Community Health Systems Office to issue *Guidelines for Using Rural-Urban Classification Systems for Public Health Assessment*.² The US Department of Agriculture's Economic Research Service (ERS) also published a recent article describing the various classification schemes it has developed and the purposes they serve,³ and it has created a web-based mapping application to help compare the alternative classification schemes which is available at

<http://www.ers.usda.gov/Data/RuralDefinitions/maps.htm>

Dichotomous Measures

Two dichotomous measures are widely used either alone or as the basis for more detailed measures, the Metropolitan Statistical Areas defined by the Office of Management and Budget (OMB), and the Census Bureau's definition of an urbanized area or urban cluster.

OMB Metropolitan and Micropolitan Statistical Areas.

The definitions of metropolitan and micropolitan statistical areas are updated annually to reflect Census Bureau population estimates. The most recent definitions were updated in November 2007 and are available at

<http://www.census.gov/population/www/metroareas/metroarea.html>

The basic unit of these statistical areas is the county. Metropolitan statistical areas include a core urban area with a population of 50,000, and a micropolitan area contains an urban area with a population of 10,000 (but less than 50,000). All other areas are considered rural.

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What is Rural continued...

Census Bureau's Urbanized Area or Urban Cluster

The Census Bureau designates census tracts—blocks or block groups—into urbanized areas and urbanized clusters. Urbanized areas have cores with populations of 50,000 or more, urban clusters have cores with populations ranging from 2500 to 49,900. All other areas are rural. The most recent urban areas and urban clusters are listed at

http://www.census.gov/geo/www/ua/ua_2k.html

Continuous Measures

Several continuous measures of rurality also exist. These include the Department of Agriculture's Economic Research Service's (ERS's) Rural Urban Continuum Codes, Rural Urban Commuting Area Codes, and Urban Influence Codes. These ERS classifications are used to “determine eligibility for Federal programs that assist rural areas.”⁴

Rural Urban Continuum Codes

This county-level classification scheme builds on the official metro-nonmetro definition of the Office of Management and Budget. Rural Urban Continuum Codes form a classification scheme that distinguishes metropolitan (metro) counties by the population size of their metro area, and nonmetropolitan (nonmetro) counties by degree of urbanization and adjacency to a metro area or areas. The metro and nonmetro categories have been subdivided into three metro and six nonmetro groupings, resulting in a nine-part county codification. A nonmetro county is defined as adjacent if it physically adjoins one or more metro areas, and has at least 2 percent of its employed labor force commuting to central metro counties.⁵

Rural Urban Commuting Area Codes (RUCAs)

The ERS's RUCAs use census tracts as the building blocks for 10 primary and 20 secondary codes that reflect geography and work commuting flows among areas. For example, “High commuting (codes 2, 5, and 8) means that the largest commuting share was at least 30 percent to a metropolitan, micropolitan, or small town core. Many micropolitan and small town cores themselves (and even a few metropolitan cores) have high enough out-commuting to other cores to be coded 2, 5, or 8; typically these areas are not job centers themselves but serve as bedroom communities for a nearby, larger city.”⁶

There is also a zip code approximation for the RUCA classification system, which is available at:

http://depts.washington.edu/uwruca/ruca1/RUCA_description.htm

Urban Influence Codes

This county-level classification scheme was developed to better capture the degree of economic integration between rural and urban areas and may be better than other methods for measuring availability of services. Metropolitan counties are divided into two groups according to size, and micropolitan counties are divided into three classifications according to their adjacency to metropolitan counties. To qualify as adjacent to a metropolitan county, a nonmetropolitan county must share a boundary with a metropolitan county and must meet a minimum work-commuting threshold. Finally, nonmetro “noncore” counties are further classified by whether or not they include a town with a population of 2500.⁷

VA Rurality Measures

The VA defines rural areas based on census tracts using a hybrid classification based on the U.S. Census definition (see above) and population density. Specifically, VA defines *urban* areas using the U.S. Census definition of urbanized areas; *rural* areas are all other areas not defined by the U.S. Census as urbanized areas; and *highly rural* areas are any rural areas within a county with fewer than 7 civilians per square mile. The VA Planning Systems Support Group offers a web-based mapping application to identify rural and highly rural areas in each VISN :

<http://vaww.pssg.med.va.gov/PSSG/maps.htm> (in the far right column, click the Urban, Rural, Highly Rural icon and then download the map that appears).

Beyond Rural Taxonomies

Establishing a geographic definition of rural is just one step to understanding rural-urban differences in mental health care access and quality. “Rural” is more complex than mere population density. For purposes of health care research, “rural” is a multi-dimensional concept encompassing sociodemographics, social networks, access to care, and the attitudes, beliefs, preferences, and norms that comprise culture.

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References

1. Hart, L. G., Larson, E. H., & Lishner, D. M. (2005). Rural definitions for health policy and research. *American Journal of Public Health*, 95(7), 1149-1155.
2. <http://www.doh.wa.gov/data/Guidelines/RuralUrban.htm>
3. Cromartie, J. Bucholtz, S. (2008) Defining the Rural in Rural America. At <http://www.ers.usda.gov/AmberWaves/June08/Features/RuralAmerica.htm>
4. ERS Briefing Rooms--Measuring Rurality: <http://www.ers.usda.gov/briefing/rurality/>
5. ERS Briefing Rooms--Measuring Rurality: Rural-Urban Continuum Codes. At <http://www.ers.usda.gov/briefing/rurality/ruralurbcon/>
6. ERS Briefing Rooms--Measuring Rurality: Rural-Urban Commuting Area Codes. At <http://www.ers.usda.gov/briefing/rurality/ruralurbancommutingareas/>
7. ERS Briefing Rooms--Measuring Rurality: Urban Influence Codes. At <http://www.ers.usda.gov/Briefing/rurality/UrbanInf/>

REPORT FROM THE SECOND NATIONAL CONFERENCE ON “IMPLEMENTING AND MAINTAINING MENTAL HEALTH CONSUMER ADVOCATE COUNCILS.”

By Carrie Edlund, M.S., M.A.

The VA Central Office recently sponsored its second national conference on Mental Health Consumer Advocate Councils in Hartford, Connecticut. Representatives from all 21 VISNs attended to learn more about the Federal Advisory Committee Act (FACA), ethics and boundaries, partnering with medical center leadership, documentation, and standard operating procedures. Ray Wodynski, CAB Recorder and Vet to Vet Program Facilitator for the Michael E. DeBakey VAMC Consumer Advisory Board, represented VISN 16 as both a participant and speaker. Mr. Wodynski spoke about the Houston consumer advisory council: where they've been, where they are now, and where they are headed. He also described some of the Houston CAB's successful programs like the quarterly telephone conferences with all councils in VISN 16.

In addition to speaking at the conference and co-leading breakout sessions, Mr. Wodynski also consulted on the updated *Mental Health Consumer/Advocate Council Guide* that will soon be available to all councils. Highlights of the updated guide include a discussion of the FACA law as it pertains to councils, and challenges and strategies for beginning and growing a consumer advisory council.

JULY CONFERENCE CALLS		ACCESS
CALL-IN NUMBER: 1-800-767-1750		CODE
14	MIRECC Leadership Council, 3:30 PM CT	19356#
15	MIRECC Program Assistants, 2:00 PM CT	43593#
21	VISN 16 Mental Disaster Team, 11:00 AM CT	76670#
27	MIRECC Education Core, 3:00 PM CT	16821#
28	MIRECC Leadership Council, 3:30 PM CT	19356#
23	National MIRECC & COE Education Implementation Science Group, 1:00 PM CT - cancelled	28791#

KEEPING UP WITH MIRECC CLINICAL EDUCATION

COGNITIVE BEHAVIORAL TREATMENT FOR REDUCING SLEEP PROBLEMS IN PATIENTS WITH PTSD-RELATED INSOMNIA

**KARIN E. THOMPSON, PH.D., C. LAUREL FRANKLIN, PH.D.,
KATHERINE FORTENBERRY, PH.D., CHARITY WILKINSON, PSY.D., AND LINDA BAGGETT, M.A.**

Sleep disturbance, one of the most widely-reported symptoms after psychological trauma¹, is a hallmark symptom of posttraumatic stress disorder (PTSD). Chronic insomnia affects emotional functioning and performance,^{2,3} and is sufficiently severe among trauma survivors to warrant individual clinical attention.⁴ While evidence-based treatments for PTSD (cognitive processing therapy, prolonged exposure therapy) have been shown to reduce PTSD symptoms, studies have shown that sleep impairment tends to remain refractory even after trauma-focused treatment. Galovski and colleagues found that while sleep disturbance was reduced as a result of evidence-based PTSD treatment, significant sleep disturbance remained.⁵ DeViva and colleagues added a specific treatment targeting insomnia for individuals who had otherwise responded to PTSD treatment and found that sleep improved.⁶ Medications have shown limited usefulness in reducing sleep disturbance. The National Institutes of Health conducted a rigorous review of all available scientific research on the treatment of insomnia and concluded that cognitive-behavioral therapies (CBT) have demonstrated efficacy in the treatment of insomnia, whereas most medications currently in use have not.⁷ Two studies of CBT treatment for insomnia among trauma survivors are available, and although neither is a controlled study, they both show promise for CBT group treatment of sleep disturbance in fire evacuees⁸ and crime victims.⁹ However, CBT for insomnia is not widely used because many clinicians are not trained in this approach.

A South Central (VISN 16) MIRECC Clinical Educator grant facilitated the development of a CBT treatment protocol for sleep disturbance in Veterans. Our aim was to develop a manualized treatment intervention based on CBT sleep strategies shown to work with other populations modified to target issues specific to PTSD-diagnosed Veterans. The 6-session treatment protocol includes educational, behavioral, and cognitive strategies that can be applied in a group or individual format. Education focuses on providing information about sleep

and sleep hygiene strategies to eliminate sleep-interfering factors and promote good sleep. Behavioral strategies include stimulus control, relaxation training, and sleep restriction. Cognitive strategies target anxiety-producing beliefs related to sleep. Home practice includes family and partner involvement. A second goal of this project was to increase clinician awareness and use of CBT for PTSD-related insomnia. Patient and therapist manuals for the PTSD Sleep Therapy Group are now available by request to Dr. Michael Kauth at Michael.kauth@va.gov.

References

1. Kilpatrick, D.G., Resnick, H.S., Freedy, J.R. (1998). Posttraumatic stress disorder field trial: Evaluation of the PTSD construct criteria A through E. In Widiger, T.A., & Frances, A.J., (Eds) *DSM-IV Sourcebook*. Washington DC: American Psychiatric Press.
2. Woodward, S.H. (1993). Sleep disturbance in posttraumatic stress disorder. *PTSD Research Quarterly*, 4-5.
3. Inman, D. J., Silver, S. M., Doghramji K. (1990). Sleep disturbance in posttraumatic stress disorder: A comparison with non-PTSD related insomnia. *Journal of Traumatic Stress*, 3, 439-437.
4. Krakow, B., Haynes, P.L., Warner, T.D., Melendrez, D., Sisley, B., Johnston, L., Hollifield, M., & Lee, S. (2007). Clinical sleep disorder profiles in a large sample of trauma survivors: An interdisciplinary view of posttraumatic sleep disturbance. *Sleep and Hypnosis*, 9, 6-14.
5. Galovski, T.E., Monson, C., Bruce, S.E., & Resick, P.A. (2009). Does cognitive-behavioral therapy for PTSD improve perceived health and sleep impairment? *Journal of Traumatic Stress*, 22, 197-204.
6. DeViva, J.C., Zayfert, C., Pigeon, W.R., Mellman, T.A. (2005). Treatment of residual insomnia after CBT treatment for PTSD: Case studies. *Journal of Traumatic Stress*, 18, 155-159.
7. National Institutes of Health. (2005, June). *NIH State-of-the-Science Conference Statement on Manifestations and Management of Chronic Insomnia in Adults*. Retrieved June 19, 2009, from <http://consensus.nih.gov/2005/2005InsomniaSOS026html.htm>.
8. Bastien, C.H., Morin, C.M., Oellet, M., France, C.B., & Bouchard, S. (2004). Cognitive-behavioral therapy for insomnia: Comparison of individual therapy, group therapy, and telephone consultations. *Journal of Consulting and Clinical Psychology*, 72, 653-659.
9. Krakow, B.J., Melendrez, D.C., Johnston, L.G., Clark, J.O., Santana, E.M., Warner, T.D., Hollifield, M.A., Schrader, R., Sisley, B.N., & Lee, S.A. (2002). Sleep dynamic therapy for Cerro Grande fire evacuees with posttraumatic stress symptoms: A preliminary report. *Journal of Clinical Psychiatry*, 63, 673 – 684.

RECOVERY CORNER

FORGET NOT THYSELF: IDENTIFYING AND PREVENTING BURNOUT

By Baris B. Konur, Psy.D.

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As VHA and the South Central MIRECC continue in their progress towards a recovery-oriented model of care, it is important for those taking care of others to be sure to take care of themselves. Burnout is one of the principle enemies of recovery implementation. It can cause those leading the charge toward recovery to give up, move on, or worse, disengage and become cynical opponents of the very thing they were working so hard to achieve. In addition, if your staff is suffering from burnout, they may be more resistant to incorporating something new into their scope of practice, further impeding progress towards recovery. In order to prevent burnout, it is important for individuals to incorporate recovery principles into their own lives. This article strives to make the connection between recovery principles and the identification and prevention of staff burnout. The article will provide a definition of burnout, identify its main components, provide signs of burnout, and suggest methods for preventing or recovering from burnout.

Burnout is a term that has been used frequently since the 1970's to describe the relationship between an individual and his or her work (Maslach, Schaufeli, & Leiter, 2001). It has been researched within a number contexts and professions (Asimeng-Boahene, 2003; Azar, 2000; Biswas-Diener, 2009; Tümkaya, 2007; Yildirim, 2008). When thought about as part of a continuum in this relationship, burnout is at one end evidenced by exhaustion, cynicism and ineffectiveness (Maslach, n.d., Maslach & Leiter, 2008). When the pendulum is swung to the opposite end, you find energy, involvement and efficacy, summed up as engagement (Maslach, n.d., Maslach & Leiter, 2008).

The three factors of burnout are emotional exhaustion, depersonalization, and reduced personal accomplishment. The first of these, emotional exhaustion, is the basic individual strain dimension of burnout, referring to feelings of being overextended and depleted of one's emotional and physical resources

(Maslach & Leiter, 2008). Depersonalization represents the interpersonal context dimension; being negative and detached from one's job (Maslach, Schaufeli, & Leiter, 2001). An example of this may be a therapist referring to a Veteran as "my schizophrenic or the PTSD guy I just had..." The personal accomplishment component represents the self-evaluative dimension and refers to feelings of inadequacy, or lack of achievement or productivity at work (Maslach, Schaufeli, & Leiter, 2001).

When taking all three of these components into account, one can think of burnout as a multi-stage process. Thinking of it as process that occurs gradually over time, as individuals begin to feel overwhelmed at work and stressed (*emotional exhaustion*), they may begin to attempt to separate themselves from their work. This *detachment* then leads them to be less personally invested in their work and their sense of *personal accomplishment* or the things that they find personally rewarding about their work declines. It is important to be able to identify signs of burnout.

Azar (2000) describes signs of burnout as including: being irritable with a low frustration tolerance; crying easily or having difficulty holding in feelings; feeling as though others are out to get you; increased substance use; stubbornness or inflexibility; isolating; appearing depressed; becoming cynical; appearing to be a "workaholic"; and spending more and more time on projects while getting less and less done. Sometimes, it is difficult to recognize these signs and symptoms in ourselves.

Ericson-Lindman and Strandberg (2007), however, found co-workers were more effective at identifying those that may be suffering from burnout.

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They found five themes in their research of those dealing with burnout: struggling to manage alone; showing self-sacrifice; struggling to achieve unattainable goals; becoming distanced and isolated; and showing signs of falling apart (i.e. touchiness, weight changes, and sleep changes). They go on to point out, however, that some of these themes are qualities that are often valued within organizations, making it somewhat difficult to identify early burnout. However, with increased awareness into these early signs and symptoms, supervisors and co-workers can be more aware and intervene sooner. Maslach and Leiter (2008) cite numerous studies that associate burnout with lower levels of patient care among nurses, increased use of violence by police officers, and negative spillover effects in work-family issues.

More recently, research has focused on the fit between the worker and the workplace (Maslach, 2001; Maslach & Leiter, 2008; Maslach & Leiter, 2005; Maslach & Leiter, 1999; Glasberg, Norberg, & Söderberg, 2007). These reviews discuss six key domains of the workplace environment: *workload* (too much work, not enough resources); *control* (micromanagement, lack of influence, accountability without power); *reward* (not enough pay, acknowledgment, or satisfaction); *community* (isolation, conflict, disrespect); *fairness* (discrimination, favoritism); and *values* (ethical conflicts, meaningless tasks). From this list, we see many of these fit with domains of recovery. A few examples include respect (community, fairness), peer support (community), empowerment (control), responsibility (workload, control), and self-direction (control, values). As activists for the principles of recovery we need to be able to apply these principles to our co-workers and ourselves.

Maslach and Leiter (2005) find that preventing or recovering from burnout can be accomplished at the individual or organizational level. These represent bottom-up (individual) and top-down (organizational) methods of dealing with burnout. In order to do this, the person or organization must find where the mismatches are and then work to find solutions in order to provide a better match. By creating a better match between people and their work, you will increase engagement, thus reducing the likelihood of burnout.

You may be thinking to yourself, “Yes but our system has always had these issues (workload, control, rewards), how am I supposed to change it?” You may not be able to, but just as recovery is a non-linear and holistic process, so is avoiding or decreasing burnout. Individuals need to do what they can within their sphere of influence in order to counteract the effects of emotional exhaustion, depersonalization and decreased personal accomplishment. The first step is to become self-aware to signs and symptoms of exhaustion and depersonalization. Once aware, you can take steps to mitigate their effect on you. Some examples of these are finding ways to reduce your stress, such as exercise, sleep, meditation, and spiritual activities. In addition, continue working to remain connected to your work and co-workers (preventing depersonalization), i.e. creating support networks with co-workers and colleagues within the VISN or local community, and establishing a mentor relationship.

Grant & Campbell (2007), also found that the more work was perceived as prosocial (benefiting others), the less likely the person was to experience burnout, and perceptions of work as prosocial may even reduce already occurring burnout. Thus, they argue that providing staff more opportunities for prosocial activities may help as well.

Burnout is recognized as both a stress phenomenon and form of mental distress (Maslach & Leiter, 2008). As such, it is important that staff and leadership are aware of burnout. As staff, we need to be conscious of those around us who may be showing signs and symptoms and be supportive of them in order to help prevent them from burning out (peer support). Leadership within all levels of VHA needs to be aware of these as well as the causes of burnout; working to provide an environment that values the input of staff (self-direction, respect, responsibility), rewards those who do a good job, allows for community (peer support), and is fair (respect). Together we can work to provide the maximum match between employees and their work, thus minimizing burnout.

References:

1. Asimeng-Boahene, L. (2003, March). Understanding and Preventing Burnout among Social Studies Teachers in Africa. *Social Studies*, 94(2), 58.
2. Azar, S. (2000, May). Preventing burnout in professionals and paraprofessionals who work with child abuse and neglect cases:

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3. A cognitive behavioral approach to supervision. *Journal of Clinical Psychology*, 56(5), 643-663.
4. Biswas-Diener, R. (2009, May). Personal coaching as a positive intervention. *Journal of Clinical Psychology*, 65(5), 544-553.
5. Ericson-Lidman, E., & Strandberg, G. (2007, October). Burnout: Co-workers' perceptions of signs preceding workmates' burnout. *Journal of Advanced Nursing*, 60(2), 199-208.
6. Glasberg, A., Norberg, A., & Söderberg, A. (2007, October). Sources of burnout among healthcare employees as perceived by managers. *Journal of Advanced Nursing*, 60(1), 10-19.
7. Grant, A., & Campbell, E. (2007, December). Doing good, doing harm, being well and burning out: The interactions of perceived prosocial and antisocial impact in service work. *Journal of Occupational and Organizational Psychology*, 80(4), 665-691.
8. Maslach, C. (n.d.). Preventing Burnout and Building Engagement. Retrieved June 12, 2009, from PsycEXTRA database.
9. Maslach, C. (2001, September). What have we learned about burnout and health?. *Psychology & Health*, 16(5), 607-611.
10. Maslach, C., & Leiter, M. (1999, September). Take this job and love it!. *Psychology Today*, 32(5), 50-50.
11. Maslach, C., & Leiter, M. (2005, Winter2005). REVERSING BURNOUT: How to rekindle your passion for your work. *Stanford Social Innovation Review*, 3(4), 42-49.
12. Maslach, C., & Leiter, M. (2008, May). Early predictors of job burnout and engagement. *Journal of Applied Psychology*, 93(3), 498-512.
13. Maslach, C., Schaufeli, W. B., & Leiter, M. (2001). Job burnout. *Annual Review Of Psychology*, 52, 397-422.
14. Rupert, P., Stevanovic, P., & Hunley, H. (2009, February). Work-family conflict and burnout among practicing psychologists. *Professional Psychology: Research and Practice*, 40(1), 54-61.
15. Schaufeli, W., & Salanova, M. (2007, June). Efficacy or inefficacy, that's the question: Burnout and work engagement, and their relationships with efficacy beliefs. *Anxiety, Stress & Coping: An International Journal*, 20(2), 177-196.
16. Tümkaya, S. (2007). Burnout and humor relationship among university lecturers. *Humor: International Journal of Humor Research*, 20(1), 73-92.
17. Yildirim, I. (2008). Relationships between burnout, sources of social support and sociodemographic variables. *Social Behavior and Personality*, 36(5), 603-616.

RECENT MIRECC PUBLICATIONS

PSYCHOTHERAPY IN THE VETERANS HEALTH ADMINISTRATION: MISSED OPPORTUNITIES?

Cully JA, Henderson L, Kunik ME, Tolpin L, Jimenez D, Petersen LA

Psychol Serv 5(4):320-331, 2008

Informed by data on the dose-response effect, the authors assessed use of psychotherapy in the Veterans Health Administration (VA). The authors identified 410,923 patients with newly diagnosed depression, anxiety, or posttraumatic stress disorder using VA databases (October 2003 through September 2004). Psychotherapy encounters were identified by Current Procedural Terminology codes for the 12 months following patients' initial diagnosis. Psychotherapy was examined for session exposure received within the 12-month follow-up period and time (in days) between diagnosis and treatment. Of the cohort, 22% received at least one session of psychotherapy, 7.9% received four or more sessions, 4.2% received eight or more sessions, and 2.4% received 13 or more sessions. Delays between initial mental health diagnosis and initiation of care averaged 57 days. Patient variables including age,

marital status, income, travel distance, psychiatric diagnosis, and medical-illness burden were significantly related to receipt of psychotherapy. Treatment delays and general underuse of psychotherapy services are potential missed opportunities for higher-quality psychotherapeutic care in health care settings.

COMPARISON OF SELF-REPORT MEASURES FOR IDENTIFYING LATE-LIFE GENERALIZED ANXIETY IN PRIMARY CARE

Webb SA, Diefenbach G, Wagener P, Novey DM, Kunik ME, Rhoades HM, Stanley MA

J Geriatr Psychiatry Neurol 21(4):223-231, 2008.

This study evaluated the Penn State Worry Questionnaire—Penn State Worry Questionnaire—Abbreviated and the Generalized Anxiety Disorder Questionnaire-IV for identifying generalized anxiety disorder in older medical patients. Participants were 191 of 281 patients screened for a clinical trial evaluating cognitive-behavior treatment, n=110 with generalized anxiety disorder, 81 without.

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Participants completed the Penn State Worry Questionnaire and Generalized Anxiety Disorder Questionnaire-IV at pretreatment. Kappa coefficients estimated agreement with the Structured Clinical Interview for Diagnosis. Receiver operating characteristic curves compared sensitivity and specificity of self-report measures. The Penn State Worry

Questionnaire (cutoff=50) provided the strongest prediction of generalized anxiety disorder (sensitivity, 76%; specificity, 73%; 75% correctly classified; kappa=.49). Item 2 of the Generalized Anxiety Disorder Questionnaire-IV demonstrated comparable accuracy. The Penn State Worry Questionnaire, Generalized Anxiety Disorder Questionnaire-IV, and briefer versions of these measures may be useful in identifying late-life generalized anxiety disorder in medical settings.

MEET YOUR CBOC: ERNEST CHILDERS VA OUTPATIENT CLINIC: TULSA, OK

PARENT FACILITY: JACK C. MONTGOMERY VAMC MUSKOGEE, OK

By Mary Sue Farmer and Kristin Ward

The Ernest Childers VA Outpatient Clinic is located in Tulsa, Oklahoma and is affiliated with the Jack C. Montgomery VAMC in Muskogee, Oklahoma. Although Tulsa, the 46th largest city in the U.S., is modern and cosmopolitan, it displays a hometown ambiance and friendliness. Perhaps that's due to its unique historical perspective that has influenced its present culture—a mix of Southern charm, Eastern elegance and Western flair.

With its past molded by Native Americans, pioneers, ranchers and forward-thinking oil barons, Tulsa today is a thriving diversified city known for its technological and aerospace enterprises. Old pipelines built to transport oil now carry fiber-optic cables transmitting data to fuel the information age. Aviation has always gone hand-in-hand with Tulsa's oil industry. After all, oil magnate W.G. Skelly built the Tulsa Municipal Airport; the world's busiest by the 1930s, when more than 300 aviation companies were located in Tulsa. American Airlines is a major employer, and the Tulsa Air and Space Museum and Planetarium is dedicated to preserving and sharing Tulsa's rich aerospace history. City-wide revitalization and growth, nationally recognized events and attractions, and a renewed enthusiasm reminiscent of the pioneering spirit, all point to a city on the move, a city poised for a prosperous future.

Part of the vital city of Tulsa is the Ernest Childers VA Outpatient Clinic which offers Primary Care, Mental Health Care, Laboratory, Physical Rehabilitation,



Nutrition and Food Service and Radiology services to the Veterans it serves. Specialty clinics include Dental, ENT, Gastroenterology, Optometry, Prosthetics,

Pulmonary Rheumatology and Spinal Cord. Mental Health services include group/individual therapy, SA, PTSD, family support groups, MST, CWT, OIF/OEF support, smoking cessation, gambling, SAFE manual, per diem grant program for homeless Veterans, and a MHICM team. The Tulsa CBOC provides services for Craig, Nowata, Rogers, Tulsa, Creek, and Washington counties.

Additionally, the Tulsa CBOC was instrumental in the development of the Veterans Treatment Court (VTC) in Tulsa. The CBOC collaborated with individuals from the Jack C. Montgomery VAMC, Tulsa Behavioral Medicine Service Substance Use Disorder Program, Tulsa County 14th Judicial District Court, the Tulsa County Drug Court Program, and the Tulsa Mayor's office. The VTC is being used as a model for others in VISN 16 and provides a much needed service for our Veterans.

We enjoyed our visit to the Tulsa CBOC and were warmly greeted by their large, efficient staff!